



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005426

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner David Ryan
Deceased:	Darren John Atkinson
Date of birth:	21 September 1973
Date of death:	Between 12 and 13 September 2024
Cause of death:	1a : Mixed alcohol and drug toxicity (clozapine, paracetamol, caffeine) 2 : Cardiac hypertrophy
Place of death:	Knaith Road Reserve Ringwood East, Victoria
Keywords:	Mental health treatment - Assessment Order

INTRODUCTION

1. On 13 September 2024, Darren John Atkinson was 50 years old when he was located deceased in a reserve in Ringwood East. At the time of his death, Darren lived in a unit in Bayswater with his dog Bridgette. He is survived by his parents, John and Jan Atkinson, and his siblings, Simone Kaissar and Scott Atkinson. Darren is warmly remembered and deeply mourned by his family.

BACKGROUND

2. Darren's medical history included schizoaffective disorder, hyperlipidaemia, hypothyroidism, hypercholesterolaemia. He had been prescribed medication by his treating clinicians, including clozapine, sodium valproate, thyroxine and rosuvastatin.
3. After he completed high school, Darren served as a reservist in the Australian Army. He had experienced issues associated with bullying and was medically discharged after 12 months due to his mental health.
4. Darren's schizophrenia was complex and treatment resistant and he had required a number of compulsory admissions to hospital in the past during periods of relapse. At the time of his death, Darren's mental health treatment was being case managed by the Murnong Community Mental Health Clinic (**MCMHC**) which is operated by Eastern Health. The lead psychiatrist at MCMHC was Dr Leela Baswa and Darren's case manager was Orpah Chibiya. Darren's family was very supportive and engaged with his care.
5. Darren had been receiving compulsory treatment under the *Mental Health and Wellbeing Act 2022* (**MHWB Act**) pursuant to a Community Treatment Order (**CTO**) which had been revoked in early November 2023, as he was accepting of treatment no longer considered by clinicians to fulfil the statutory criteria. After that time, he was receiving care from the team at MCMHC as a voluntary consumer. Darren's family was very worried about the revocation of the CTO as, although he was stable at that time, they were concerned about potential medication non-compliance in the event of relapse. It was recorded that Darren's treating team would continue to case manage him, there would be no changes to his medication management and they would arrange for hospitalisation if required.

THE CORONIAL INVESTIGATION

6. Darren's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.
7. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.
8. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.
9. Section 7 of the Act provides that a coroner should liaise with other investigative authorities, official bodies or statutory officers to avoid unnecessary duplication of inquiries and investigations and to expedite the investigation of deaths.
10. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Darren's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. Further evidence was obtained by the Court directly from Victoria Police and Eastern Health. Also, Jan and Simone forwarded correspondence to the Court in which they expressed concerns about Darren's treatment and management by Eastern Health.
11. On 12 November 2025, I refused a request from Simone that an inquest be held into her brother's death.¹
12. This finding draws on the totality of the coronial investigation into Darren's death including evidence contained in the coronial brief. While I have reviewed all the material, I will only

¹ Form 28 – Decision by Coroner whether an Inquest will be held into a Death, dated 12 November 2025.

refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.²

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

13. On 2 September 2024, Darren made an unscheduled visit to MCMHC. He told a nurse that he wanted to say that he always had love in his life and felt light and well. Ms Chibiya was on leave at the time and was advised of Darren's visit by email.
14. On 9 September 2024, Darren had a telephone review with Ms Chibiya. Darren stated that he no longer needed sleep or his medication. He also expressed frustration that nobody was helping him to publish his story and he indicated his distress by asking "*Do you want me to kill myself?*". Ms Chibiya sought to reassure Darren and "*checked with him if he was safe*". Darren confirmed that he was safe but frustrated. Ms Chibiya was concerned that Darren was at risk of ceasing his medication which could lead to a further deterioration in his mental state and arrangements were made to bring forward his scheduled review with a psychiatrist. Further, she encouraged him to continue taking his medication. Ms Chibiya also noted that she would liaise with Darren's family. There is no evidence that Darren's family were contacted.
15. In the morning on 12 September 2024, Darren attended MCMHC for a medical review with psychiatry registrar Dr Yachna Mehta and Ms Chibiya. During the consultation, Darren told Dr Mehta that he no longer had schizophrenia and had ceased his medication on 10 September 2024. His presentation was noted to be agitated with tangential and disorganised thoughts but he did not express any suicidal ideation. Dr Mehta expressed concern to Darren that ceasing his medication may lead to a relapse in his illness resulting in a hospital admission. Darren dismissed her concerns and became irritable.
16. Dr Mehta asked Darren to step outside the consulting room to the waiting room while she consulted with Dr Baswa. Dr Baswa suggested that collateral history be obtained from Darren's family after which a decision could be made to either engage the Crisis Assessment and Treatment Team (CATT) to supervise his medication and monitor his mental state or he

² Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

- could be placed on an Assessment Order under the MHWB Act if he continued to refuse his medication.
17. Dr Mehta contacted Simone to gain further insight into Darren's recent mental health and to discuss treatment options. Simone expressed concern about Darren's refusal to take his medication as his mental health may deteriorate and he may become violent. She stated that she would prefer Darren to be in hospital if he was not taking his medication.
 18. While Dr Mehta was reviewing Darren's treatment plan, he left the clinic. Dr Mehta telephoned him and requested that he return for treatment, otherwise an Assessment Order would need to be made under the MHWB Act. Darren advised that he would think about it and then ended the call. He did not return to the clinic.
 19. At around 12.41pm, after further consulting with Dr Baswa, Dr Mehta made an Assessment Order under the MHWB Act given that Darren appeared to be refusing treatment and required an admission to hospital to supervise his medication. This was intended to be an Inpatient Assessment Order. She also contacted Simone to notify her that Darren had absconded from the clinic during a consultation and an Assessment Order had been made. Dr Mehta tried to contact Darren later that afternoon but he did not respond.
 20. Ms Chibiya contacted Boronia Police Station to advise that an Assessment Order had been made in relation to Darren and requested police assistance to apprehend him from his home and transport him to hospital. She subsequently emailed the Assessment Order to the station at 3.22pm. Later that afternoon, a copy of the order was provided to the police members who were patrolling the Boronia area in the divisional.
 21. Simone went to Darren's unit to look for him but he was not there. She left a note for her brother to let him know that she was looking after his dog. She also tried to unsuccessfully to contact him on his phone later that afternoon.
 22. At around 5.47pm, Simone attended the Boronia Police Station and asked whether they had completed a welfare check on Darren as she was concerned about the deterioration in his mental health. She recalled that police advised that they planned to conduct welfare check later that evening.
 23. In the morning on 13 September 2024, Simone tried to contact Darren on his phone but he did not answer. Also that morning, police at Boronia Police Station contacted Ms Chibiya and advised that they did not currently have a unit available to attend Darren's house and suggested

that she attend and contact emergency services if required. Shortly afterwards, a copy of the Assessment Order was forwarded to the Divisional Patrol Sergeant at Knox Police Station and they awaited contact from Ms Chibiya in the event that Darren was found at home.

24. At around 11.30am, Ms Chibiya attended Darren's unit with another staff member. She met with Jan at the unit who provided access, but Darren was not home.
25. At around 1.00pm, Simone attended Boronia Police Station and reported Darren missing. Further, Ms Chibiya contacted police again at around 2.00pm to request a welfare check at Darren's unit and reiterated the risks associated with his medication non-compliance. A welfare check was subsequently arranged for later that afternoon but it did not occur before Darren was found deceased.
26. At around 2.45pm, Darren was located deceased by two passersby in some bushes in the Knaith Road Reserve in Ringwood East. They contacted emergency services and Ambulance Victoria and Victoria Police subsequently attended the scene. Paramedics pronounced Darren deceased at 3.03pm. Knaith Road Reserve is approximately 750 metres from MCMHC.
27. At the scene, police members located empty packets of Panadol and clozapine and two empty bottles of wine. Receipts were also located which indicated that Darren had purchased a number of items in the afternoon on 12 September 2024 from the Ringwood East IGA, including Panadol and wine. Further, they located a note which appeared to have been written by Darren in which he expressed his love for his family and his regret at not being able to see a way out of his predicament. Its contents are consistent with an intention to take his life.
28. Victoria Police did not find any evidence of suspicious circumstances.

Identity of the deceased

29. On 13 September 2024, Darren John Atkinson, born 21 September 1973, was visually identified by his sister, Simone Kaissar.
30. Identity is not in dispute and requires no further investigation.

Medical cause of death

31. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine performed an autopsy on 20 September 2024 and provided a written report of her findings dated 22 January 2025.

32. Dr Archer observed that Darren had an enlarged heart which can be associated with cardiac arrhythmia.
33. Toxicological analysis of post-mortem samples identified the presence of alcohol (0.13g/100mL), clozapine,³ paracetamol and caffeine.⁴ Dr Archer noted that the levels of caffeine, clozapine and paracetamol detected were in the toxic range which when combined with alcohol may cause central nervous system and respiratory depression, arrhythmias, seizures and liver failure.
34. Dr Archer provided an opinion that the medical cause of death was *1(a) Mixed alcohol and drug toxicity (clozapine, paracetamol, caffeine), 2 Cardiac hypertrophy*.
35. I accept Dr Archer's opinion.

FAMILY CONCERNS

36. Jan and Simone expressed concerns to the Court in relation to Darren's treatment and management by Eastern Health. Clinicians from Eastern Health met with Darren's family to discuss their concerns and extend their condolences. The Court also obtained a statement from Dr Baswa which provided a summary of their recent involvement with Darren and which responded to the family's concerns.
37. In particular, Dr Baswa stated and clarified the following:
 - a) Darren's question to Ms Chibiya on 9 September 2024, "*Do you want me to kill myself?*", was understood in context as an expression of frustration and as suicidal ideation was denied on medical review a few days later, it was not appropriate to take further action based upon that question alone.
 - b) As Darren was a voluntary consumer at the time he left MCMHC on 12 September 2024, staff were not in a position to prevent him from leaving. Further, Darren was not assessed to be at immediate risk or distress when he was asked to step into the waiting room.
 - c) Eastern Health regrets the distress caused to the family as a result of them not being invited to a meeting after Darren's attendance at MCMHC on 9 September 2024. They

³ Clozapine is an antipsychotic drug effective for treating schizophrenia.

⁴ Caffeine can be derived from stimulant drinks, but is also potentially derived from over-the-counter medications, such as combination paracetamol products.

acknowledged the importance of family involvement in Darren's care and will take the matter seriously to ensure clearer communication and documentation in the future.

- d) As an oversight, the box on the Assessment Order form indicating that an Inpatient Assessment Order was being made was not ticked.

38. An In-depth Case Review was conducted by Eastern Health following Darren's death which found as follows:

- a) Darren's mental health had worsened in the immediate period before his death, which was clear during his appointment on 12 September 2024. At that time, because he was not judged to be an immediate risk, Darren was asked to wait while the team planned his care. Unfortunately, he left the clinic during this time. The team discussed how to manage such situations and noted that keeping doors locked is decided case-by-case, as it can sometimes cause other safety concerns and distress to other patients. The clinic's upcoming move to new premises in 2025 will offer improved security.
- b) When Darren was placed on an Assessment Order, there were delays in police responding. This is a known issue, and work is underway with police to improve communication between services and make the process quicker and safer.
- c) On 2 September 2024, Darren had an unscheduled visit to the clinic and was seen briefly. The case manager was informed but was on leave, so follow-up was delayed until 9 September 2024. At that time, early signs of concern were noted and his next appointment was brought forward. The review recommended improvements to how unscheduled visits are handled, including better assessments and communication to ensure timely support.

FINDINGS AND CONCLUSION

39. It is clear that Darren was experiencing a relapse of his mental illness in the context of insomnia and the ceasing of his medication. Having considered all of the circumstances, I am satisfied that Darren intentionally took his own life in the context of his deteriorating mental health.

40. The clinicians at MCMHC appropriately made an Assessment Order as Darren was refusing treatment and they considered that he required compulsory treatment in hospital. However, in the period leading up to the making of the order, MCMHC could have been more proactive in including Darren's family in his treatment planning.
41. Unfortunately, Darren was not located and detained before he took his life. Given that it was confirmed on a number of occasions by Darren's family and his case manager that he had not returned home, there was perhaps a missed opportunity to search for him in the area where he was last seen. However, even if an earlier search had been conducted in the vicinity of MCMHC, there is no guarantee that Darren would have been located prior to him taking his life.
42. Darren was deeply loved by his family. His ongoing struggle with his mental health was relentless and exhausting for him. His family's involvement with various health services as they supported Darren through his difficult journey was clearly a frustrating and unsatisfying experience for them and understandably his death has left them devastated.
43. In 2019, the Royal Commission into Victoria's Mental Health System was established after the Victorian Government recognised that the system was failing to support people living with mental illness or psychological distress, families, carers and supports, as well as those working in the system. On 2 March 2021, the Royal Commission's final report was tabled in Parliament which included 65 recommendations which the Victorian Government has committed to implementing over the following 10 years.⁵
44. The Commission also acknowledged that families, carers and supporters can feel excluded by the system, and are often left out of engagement that would help them in their caring role.
45. Pursuant to section 67(1) of the Act, I make the following findings:
 - a) the identity of the deceased was Darren John Atkinson, born 21 September 1973;
 - b) the death occurred between 12 and 13 September 2024 at Knaith Road Reserve Ringwood East Victoria, from mixed alcohol and drug toxicity (clozapine, paracetamol, caffeine) and cardiac hypertrophy as a contributing factor; and

⁵ Royal Commission into Victoria's Mental Health System, 'Final Report' published February 2021 (available at <https://finalreport.revmhs.vic.gov.au/>).

c) the death occurred in the circumstances described above.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. Murnong Community Mental Health Clinic review its process, procedures and training to ensure that, wherever possible and appropriate, staff involve family in the treatment planning of their clients.

I convey my sincere condolences to Darren's family for their loss.

I direct that a copy of this finding be provided to the following:

Jan & John Atkinson, Senior Next of Kin

Simone Kaissar

Eastern Health

Chief Commissioner of Police, c/o Lander & Rogers

Office of the Chief Psychiatrist

Senior Constable Jarrod Lee, Coronial Investigator

Signature:



Coroner David Ryan

Date: 18 November 2025



NOTE: Under section 83 of the *Coroners Act 2008* ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.
